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Supreme Court, U.S.
FILED

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No.

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In the

Supreme Court of the United States

DONALD E. CONLEY,

Petitioner,

versus

PITNEY BOWES, a corporation, PITNEY BOWES LONG TERM DISABILITY PLAN; GEORGE B. HARVEY and CARMINE F. ADIMANDO, as Trustees of PITNEY BOWES LONG TERM DISABILITY PLAN, PITNEY BOWES GROUP LIFE INSURANCE PLAN; PITNEY BOWES MAJOR MEDICAL EXPENSE PLAN; PITNEY BOWES DENTAL EXPENSE PLAN; and MICHAEL CRITELLI,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

I. Does an ERISA long term disability plan and those with decision making power breach their fiduciary duty under Section 404(a)(1) of ERISA by structuring a program toward a disability claimant that uses for evaluative and decision making purposes a doctor whose major source of annual income is the preparation of defense testimony and defense reports used in highly adversarial proceedings and who enjoys no reputation for fairness or accuracy?

II. If the trial court relieves a long term disability claimant from restriction to the plan administrative record that the plan fiduciaries developed, because the claimant was denied by the ERISA welfare benefit plan and those administering the plan an opportunity to particpate in the development of the record and a full and fair review under the Secretary's regulations promulgated under the authority of Section 503 of ERISA, should the plan and plan fiduciaries likewise be entitled to offer evidence outside their own administrative record without any showing why such new evidence is needed or should be accepted?

III. Under long term disability ERISA plans which provide for social security disability payments to reduce the monthly amount the ERISA welfare plan will pay, do the principles of *Cleveland v. Policy Management Systems Corp., 119 S.Ct. 1597 (1999)* apply so that the plan decision maker is required to explain why no significant weight was given to a favorable disability determination by the Social Security Administration (SSA) when the definition of disability in the plan terms and that used by the SSA are substantially the same?

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PETITION FOR WRIT OF CERTIORARI

Petitioner respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit, which affirmed the decision of the district court, on May 7, 1999, so that this Court might resolve the very same sort of question that this Court has recently advised it would resolve by this Court's grant on September 28, 1999 of review of the decision of the Seventh Circuit in *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1999), that is, the extent under which a plan may operate and be structured in its operations without violating fiduciary duties. There are two compelling reasons for review: First, the strong Congressional desire for national uniformity in enacting the Employee Retirement Income Security Act ((ERISA), a goal often expressed by this Court in ERISA decisions, and second, the view of the Eighth Circuit that this Court did not mean by phrase "uncompromising rigidity" it accepted in *NLRB v. Amax Coal Co.*, 453 U.S. 322, 333-34 (1981) as defining the fiduciary's role, so that only the most obnoxious and egregious kinds of fiduciary misconduct is subject to correction. Thus the Eighth Circuit said the respondents' use of what is called in the vernacular a "workers' compensation defense hack" for evaluation, is irrelevant.

The second question should be accepted for review because of a split in the Circuits. In the instant case the Eight Circuit allowed the district court, and it itself used, testimony offered by the respondents outside the respondents' own administrative record when respondents' offered no reason why such testimony was necessary. Only recently the Ninth Circuit in *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1111 (9th Cir. 1999) suggested ordinarily only the claimant who is

denied a full and fair review, is entitled to offer new evidence not in the administrative record.

The third question should be accepted for review because of the split in the circuits. In the instant case the Eight Circuit holds that even if the definition of disability is the same as that used for disability determinations by the SSA, the plan's decision maker is free to ignore the government's determination of disability and need offer no explanation for this decision. Not all circuits agree that SSA findings of disability qualification are irrelevant: *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, ___ F.3d ___, 1999 Westlaw 989387 (7th Cir. 1999); *Whatley v. CNA Ins. Cos.*, 189 F.3d 1310, 1313 (11th Cir. 1999)

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eighth Circuit, rendered June 10, 1997, is reported at 176 F.3d 1044, and is reprinted in the appendix hereto as A-1a to A-12a. A petition for rehearing or rehearing en banc was denied June 24, 1999, appears in the Appendix as A-34a. The opinion of the United States District Court for the Eastern District of Missouri, is published at 978 F.Supp. 892, and is reprinted in the Appendix at A-13a to A-33a.

JURISDICTIONAL STATEMENT

The district court had jurisdiction of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §§1132(a).

An appeal was taken to the Eighth Circuit Court of Appeals pursuant to 28 U.S.C. §1291. The judgment of the Court of Appeals was entered May 7, 1999. Petitioner filed a petition for rehearing by the panel or, alternatively, for

rehearing en banc. The Court of appeals denied the petition June 24, 1999.

Pursuant to Supreme Court Rule 13, on application of petitioner Justice Thomas on September 14, 1999, granted an extension to petitioner to file this petition until November 15, 1999. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254.

STATUTES INVOLVED

ERISA §404(a)(1), 29 U.S.C. §1104(a)(1), provides:

> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;

ERISA §503, 29 U.S.C. §1132, provides:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for

benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

STATEMENT OF THE CASE

Petitioner had serious past lower back problems, resulting in major surgery in the mid 1970s that by 1989 was coming "undone." He also suffered degenerative changes, scoliosis, spinal stenosis and degenerative joint disease in the lower back. In 1989 he suffered what the trial court found to be only a minor motor vehicle accident. Thereafter petitioner did not return to work. Respondents found him eligible for both short term disability benefits, and for such time under the ERISA long term disability plan as the definition was unable to do his former job (the first two years). Petitioner also filed at the time of the vehicular accident a claim against the plan sponsor under the state worker's compensation law for that part of his disability attributable *only* to the accident. The state action is adversarial, and respondents hired adversarial doctors to aid them in the defense of that state claim.

A great part of the annual income of the doctor respondents retained for defense of the state action, came from such defense work; he had never been retained to testify for the other side (workers), they viewed him as totally unfair and his reputation was that of an unfair defense doctor. Petitioner offered further evidence that even the insurance company that was instrumental in his retention, did not find the doctor or his evaluation credible or accurate.

Respondents instructed petitioner to apply for Social Security benefits. Petitioner did apply as instructed, and later was awarded disability benefits by the Social Security

Administration. Respondents' administrative record revealed they were aware of the SSA determination and that they had taken advantage of it to reduce their own disability payments to petitioner during the first two years of plan eligibility for LTD benefits.

The "administrative record" respondents claimed they used to later determine no further disability, when under the plan the definition of disability changed from inability to do one's own job, to that used by the Social Security Administration ("any job") , was the same record they earlier developed as adversaries to defend in the adversarial workers' compensation proceeding. At the time respondents announced they would discontinue petitioner's LTD benefits, they said it was because of the proposed rating by their highly adversarial doctor used for defense. About one year later respondents said it was because petitioner had settled his state claim based on such rating, but petitioner and his state attorney denied such, and not even the trial or appellate courts gave such proffered meaning to the state workers' compensation settlement. After petitioner filed suit, respondents once again changed their reason for discontinuance, then stating that the plan definition required there to be objective findings only, that pain even if unquestioned and disabling, was not sufficient. At no time, even at trial, did any witness, challenge the sincerity of petitioner's complaint of disabling pain.[1] No plan language supported the assertion that only objective evidence will be

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[1]Notwithstanding this uncontradicted testimony, the Eighth Circuit cedes to the district court some unknown medical expertise. A-6a. As pointed out in note 2 the district court was determining only that the minor accident could not believably cause the disabling pain.

considered.[2] No doctor, not even the defense doctor respondents used, ever certified or testified petitioner was ever able to return to his own job or to any meaningful job in the economy.

In denying the continuation of LTD benefits, respondents did not meet the requirements of their own plan, or the Secretary's regulations. Nonetheless the district court initially granted summary judgment to respondents for failure of petitioner to exhaust. The Eight Circuit in an earlier appeal, revered the dismissal and remanded without instructions. *Conley v. Pitney Bowes, Inc.*, 34 F.3d 714 (8th Cir. 1994). After remand respondents proposed to proceed administratively, but they would not specify how they would further proceed or investigate, nor would they commit to desist from doctor shopping nor commit themselves to conduct a "full and fair review" that ERISA §503 and the Secretary mandate. They certainly did not propose to comply with the Secretary's requirement to tell petitioner what more information he might provide. 29 C.F.R.

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[2]After trial the district court, affirmed by the Eighth Circuit, appeared to determine the test would be how serious the recent 1989 accident was to cause this inability. A-29a to A-30a ("plaintiff's claimed ***injury*** lacked credibility"). The Eighth Circuit so characterized it as well. A-3a ("the court itself would conclude that Mr. Conley's alleged ***injury*** lacked believability"). No plan language premises inability to perform on the seriousness of any most recent accident; the plan does not exclude preexisting conditions that flare up. No such limiting plan requirement was cited by either court. Accident is not even required under the terms of the plan for one to be eligible for benefits; no plan terms specify etiology or causative limitations.. There is no reason that preexisting conditions that flare up, should not be considered. The plan allows accident or illness; chronic conditions are not excluded.

2560.503-1(f)(3),[3] The district court rejected respondents' proposal when put in the form of a motion, but twice warned petitioner that at trial he would be bound by the existing workers' compensation defense record respondents had already developed in their defense of the state action, as the administrative record.

At trial, petitioner offered deposition testimony of his treating physician who was clear why petitioner could not perform any job. Petitioner argued that respondents had never given him notice of the quality demanded by the Secretary, 29 C.F.R. 2560.503-1(f), and that had he received such notice, he would have at least gotten that into the administrative record[4] Respondents took the deposition of their adversarial doctor who helped in their defense of the petitioner's worker's compensation claim, and offered such at trial over petitioner's objection that respondents were bound by their own administrative record. Long after the trial, upon issuing its decision the district court said for the first time that it would also consider the cause as if tried *de novo*, and then relied on the testimony of respondents' adversarial doctor, citing no other specific medical evidence from any other medical doctor, to justify his finding that the recent vehicular accident could not believably cause all the pain about which petitioner complained, as if such accident were relevant. A-29a to A-30a. See note 2. Not even respondents' adversarial doctor had testified at any earlier time that he had certified that petitioner could return to any

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[3]The regulation requires respondents to provide "a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary."

[4]Petitioner also claimed that respondents had a duty to investigate, and part of this duty was to enquire of the views of the treating physician.

employment. The plan is in terms of ability to perform, not whether an injury of any certain severity has occurred or what was plaintiff's claimed ***injury*** from an accident.

REASONS FOR GRANTING THE WRIT

I. ERISA welfare plans should not be structed so that those making fiduciary decisions, may be conflicted or ignore their fiduciary and statutory duties.

The Eighth Circuit in its Point I, 3a to 5a, raises the same issue as this Court is to consider in *Herdrich v. Pegram*, *supra*. There the plan beneficiary was denied a benefit at a time when she most needed it. She had a right to bring an action for a benefit the very moment the doctor decided to delay. There is no suggestion in the *Herdrich* petition for certiorari or in the opinions below in that case, that the incentive arrangement had ever been applied to create an adversity for any other participant or beneficiary. There was no showing of systematic abuse of such a incentive arrangement, and the record shows only one person – Ms.Herdrich – had been injured. Nor will Ms.Herdrich's showing of fiduciary misconduct effectively "remedy the harms [s]he has allegedly suffered," as the Eighth Circuit puts it, A-4a.

Striking the incentive system in *Herdrich* will not correct the physical harm Ms. Pegram had suffered,[5] 5and as the Eighth Circuit puts it, if the only relief to be provided is "to a plan and not to individual beneficiaries", A- 4a, Ms. Herdrich would have no basis to proceed under the Eighth Circuit rationale in the instant case. If in *Herdrich* Ms.

[5]In fact, she did recover for the harm suffered in the malpractice action against the doctor.

Herdrich is entitled to relief, albeit no plan benefit, so too may petitioner be entitled to some form of relief, even if not a monetary disability benefit for himself, for a philosophy by respondents that it is permissible to use adversarial doctors they had previously retained for adversarial proceedings on the very same subject matter.

It is submitted that if *Herdrich* is affirmed, then it may be appropriate to vacate the judgment of the Court of Appeals in the instant case, to allow for further consideration.

II. If *de novo* review is granted to particpant, plan fiduciaries should be restricted to administrative record they had full control in developing unless they make a clear showing that they were unable to develop the same earlier.

The district court, affirmed by the Eighth Circuit, relied heavily on the meanings it derived from the later testimony of respondents' most adversarial doctor that was offered through deposition taken by respondents after the denial and *outside* the confines of the administrative record. Respondents did not offer to the district court any reason for the need to offer his testimony. Their administrative record had all his written reports. They did not claim, nor could they, that what they asked to testify about, was not earlier unavailable to them. Even then, as noted, this adversarial doctor was not asked by respondents if there were any jobs he could certify petitioner could have performed at the time of benefit denial, and the respondents' own unilaterally developed administrative record reveals this doctor had advised respondents that in his view petitioner's condition was such that notwithstanding the risks of major surgery and

the possibility surgery might not even work, it was his recommendation that petitioner should take the risks.

If a party has full and adequate opportunity to participate in the making of the administrative record, then he is bound by it. Respondents had full opportunity. They should be bound by the administrative record they not only had full control over, but made sure that while it was being prepared, that petitioner was given no opportunity to participate in its making. The Eighth Circuit says *de novo* is for everybody, the wronged and wrongdoer alike, but other circuits do not agree. *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1111 (9th Cir. 1999) suggested ordinarily only the claimant who is denied a full and fair review, is entitled to offer new evidence not in the administrative record, not the plan or plan fiduciaries.

The instant case allows determination of this issue as well.

III. The circuits are likewise split on the relationship of SSA findings with disability determinations.

The Eighth Circuit ignores this Court's recognition of the meaning of Social Security determinations in *Cleveland v. Policy Management Systems Corp.*, 119 S.Ct. 1597 (1999). The Eighth Circuit would not require the respondents who instructed petitioner to apply for social security so they could, as they did, reduce the amount of what they paid under the plan by the amount SSA paid, to explain why, with plan definitions substantially the same as that used by the SSA, they do not accept or give significant weight to the SSA determination. The Eighth Circuit sought to suggest it found no conflict weith the Seventh Circuit, but it is now clear the Seventh Circuit would not require the respondents to provide

counsel for the Social Security proceeding before it would look to see if there was any plan basis for not giving SSA determinations great weight. *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, ___ F.3d ___, 1999 Westlaw 989387 (7th Cir. 1999) (look to see if plan definition different from definition from that used in Social Security). See also, *e.g.*, *Whatley v. CNA Ins. Cos.*, 189 F.3d 1310, 1313 (11th Cir. 1999). Under the circumstances review is appropriate for this difference in the circuits and for the extent of the relationship this Court addressed in *Cleveland v. Policy Management Systems Corp.*

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,
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(Any footnotes trail end of each document)

No. 97-3963

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Donald E. Conley,
Appellant,

v.

Pitney Bowes, A Corporation; Pitney Bowes Long Term Disability Plan; George B. Harvey and Carmine F. Adimando, As Trustees of Pitney Bowes Long Term Disability Plan; Pitney Bowes Group Life Insurance Plan; Pitney Bowes Major Medical Expense Plan; Pitney Bowes Dental Expense Plan; and Michael Critelli,
Appellees.

May 7, 1999, Filed

COUNSEL:
Counsel who presented argument on behalf of the appellant was S. Sheldon Weinhaus of St. Louis, Missouri.

Counsel who presented argument on behalf of the appellee was Keith A. Rabenberg of St. Louis, Missouri. Also appearing on the brief was Clark H. Cole.

JUDGES:

Before WOLLMAN, LOKEN, and MORRIS SHEPPARD ARNOLD, Circuit Judges.

OPINIONBY:
MORRIS SHEPPARD ARNOLD

OPINION:

MORRIS SHEPPARD ARNOLD, Circuit Judge.

Donald Conley was injured in an automobile accident while working for Pitney Bowes. He received short-term disability benefits for a time after the accident and was then placed on long-term disability status, as provided for by the Pitney Bowes employee welfare plan. The terms of the plan state that in order to receive long-term disability benefits during the first 12 months after an employee allegedly becomes totally disabled, the employee needs only to be "unable to perform his own occupation." In order to receive long-term disability benefits for more than 12 months, however, an employee needs to be "unable ... to engage in any gainful occupation or profession for which he is, or could become, reasonably suited by education, experience, or training."

Pitney Bowes informed Mr. Conley by letter that his long-term disability benefits would be terminated after 12 months because he did not meet the stricter standard for additional benefits. Mr. Conley did not respond to the letter and sometime later he was given the choice of taking three months of personal leave or resigning. Mr. Conley then replied that he was unable to return to work at that time but hoped that he would eventually be able to do so; he also announced his intention to sue Pitney Bowes for the continuation of his long-term disability benefits. Pitney

Bowes heard nothing more from Mr. Conley and eventually informed him that his employment was terminated.

Mr. Conley then sued Pitney Bowes under the Employee Retirement Income Security Act (ERISA), *see 29 U.S.C. § § 1001*-1461, seeking review of the denial of additional long-term disability benefits, *see 29 U.S.C. § 1132*(a)(1)(B), § 1132(a)(3), and also alleging breach of fiduciary duty, *see 29 U.S.C. § 1109*(a), § 1132(a)(2), § 1132(a)(3), and wrongful discharge, *see 29 U.S.C. § 1140.* The trial court[1] dismissed the fiduciary duty claim under Fed. R. Civ. P. 12(b)(6), *see Conley v. Pitney Bowes, Inc., 1997 U.S. Dist. LEXIS 18126, 1997 WL 695581* (E.D. Mo. Jan. 24, 1997).

At a subsequent bench trial, the court reviewed the plan administrators' decision to deny benefits, considering only the administrative record that existed at the time of the plan administrators' decision, and concluded that the denial was reasonable and supported by substantial evidence. The trial court added that if it were to review the evidence *de novo,* including some that the plan administrators did not have before them, the court itself would conclude that Mr. Conley's alleged injury lacked believability and that he did not meet the requirements for additional long-term disability benefits under the plan. Finally, the trial court found that Pitney Bowes did not wrongfully discharge Mr. Conley, *see Conley v. Pitney Bowes, Inc., 978 F. Supp. 892 (E.D. Mo. 1997). See also Conley v. Pitney Bowes, 34 F.3d 714 (8th Cir. 1994).* Mr. Conley appeals, and we affirm.

I.

Mr. Conley argues that the trial court should not have dismissed his claim for breach of fiduciary duty. Mr. Conley described the alleged fiduciary violations as failure to

him with proper notice of his opportunity to appeal, failure to maintain a complete administrative record, and failure to conduct a full and impartial investigation of his condition. Mr. Conley sought equitable relief in the form of a restoration to him of past and future additional long-term disability benefits; he also sought reform of the claim procedure generally and removal of the fiduciaries or the appointment of an ombudsman.

Part of the enforcement statute for ERISA, *see 29 U.S.C. § 1132*(a)(2), provides a cause of action for breach of fiduciary duty under *29 U.S.C. § 1109*(a), which states that a fiduciary who breaches his or her duty is personally liable for losses to the plan and subject to "such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary." As the trial court noted, however, § 1109(a) provides relief only to a plan and not to individual beneficiaries. *See Varity Corp. v. Howe, 516 U.S. 489, 515, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996), see also id. at 509.*

Mr. Conley therefore does not have a cause of action for the restoration of additional long-term disability benefits under § 1132(a)(2) in conjunction with § 1109(a). Although § 1132(a)(2) does authorize a participant or beneficiary to seek relief for a plan, Mr. Conley has not shown how reform of the claim procedure or removal of the fiduciaries will remedy the harms he has allegedly suffered, nor has he produced evidence of a pattern or practice of fiduciary violations that require reform. We thus conclude that Mr. Conley has not stated a claim for which relief can be granted under § 1132(a)(2), either for himself or for the plan as a whole.

Nor does Mr. Conley have a claim for equitable relief in the form of benefits under § 1132(a)(3)(B), which provides a participant, beneficiary, or fiduciary with an action to obtain

appropriate equitable relief to redress violations of the provisions of a plan or to enforce any such provisions. We have held that where a plaintiff is provided adequate relief by [the] right to bring a claim for benefits under § 1132(a)(1)(B)," the plaintiff does not have a cause of action to seek the same remedy under § 1132(a)(3)(B). *Wald v. Southwestern Bell Corporation Customcare Medical Plan, 83 F.3d 1002, 1006 (8th Cir. 1996).* Mr. Conley has a claim for benefits under § 1132(a)(1)(B) and therefore may not seek the same benefits in the form of equitable relief under § 1132(a)(3)(B). Nor may he bring an action for planwide relief under § 1132(a)(3)(A), since, as noted above, he has not pleaded a systematic error or abuse in need of reform. We therefore affirm the trial court's dismissal of Mr. Conley's claim for breach of fiduciary duty.

II.

Mr. Conley further asserts that the trial court erred when it found in favor of the defendants on his claim for additional long-term disability benefits. We review the trial court's findings of fact for clear error and its conclusions of law *de novo. See Planned Parenthood of Greater Iowa, Inc. v. Atchison, 126 F.3d 1042, 1048 (8th Cir. 1997).*

Mr. Conley first contends that the plan administrators and the trial court gave too much weight to the diagnosis of Dr. Daniel Phillips, a physician who regularly conducts examinations for insurer-defendants in workers' compensation claims. Mr. Conley suggests that Dr. Phillips's finding of minimal objective symptoms was biased and that the 8 percent permanent partial disability rating that Dr. Phillips gave to him was meaningless. Second, Mr. Conley argues that chronic pain itself constituted a disability and that the plan administrators and the trial court ignored his

evidence of disabling pain, including the fact that he was taking narcotics, the fact that several doctors recommended surgery as a possible option, and the reports of a nurse who witnessed him moving with difficulty.

There was, however, considerable evidence in the record besides Dr. Phillips's report to support the finding that Mr. Conley was not totally disabled as defined by the plan. The trial court was in the best position, moreover, to judge the credibility of Mr. Conley's testimony with respect to pain. We cannot say that "on the entire evidence" we are "left with the definite and firm conviction that a mistake has been committed," as we must to do in order to find a trial court's factual findings clearly erroneous. *United States v. United States Gypsum Co., 333 U.S. 364, 395, 92 L. Ed. 746, 68 S. Ct. 525 (1948).*

III.

Mr. Conley also maintains that the trial court committed numerous errors of law. First, he objects to the standard of review that the trial court applied to the defendants' determination that he was not eligible for additional long-term disability benefits. The trial court correctly noted that since the terms of the plan grant explicit discretionary authority to the employee benefits committee to construe the plan and to determine a claimant's eligibility for benefits, the deferential "abuse of discretion" standard of review would ordinarily be appropriate. *See Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989); see also Donaho v. FMC Corp., 74 F.3d 894, 898 (8th Cir. 1996).* Where a claimant is able to point to a significant procedural irregularity that resulted in a serious breach of the administrator's fiduciary duty, however, a stricter and less deferential standard may apply. *See Wald, 83*

F.3d at 1007. Mr. Conley contended at trial that this stricter standard was the appropriate one for his case.

The trial court was disturbed by two apparent violations of the provisions of the plan that might have amounted to a significant procedural irregularity, namely, the unauthorized delegation of decision-making power to the medical director of the defendants' disability department and the absence from the records of a written explanation of the rationale for the decision that Mr. Conley was not totally disabled (as defined by the plan). The trial court decided that it did not need to reach a conclusion on the standard of review, however, because it would uphold the defendants' decision under either standard. Indeed, the trial court said that its conclusion would be the same if it applied a *de novo* standard of review to the record established by Pitney Bowes at the time of the decision to deny additional long-term disability benefits to Mr. Conley; the trial court also stated that its conclusion would only be further bolstered by a consideration of supplemental evidence offered by the parties beyond that contained in the administrative record.

Mr. Conley asserts that the trial court maintained throughout the trial, over his objection, that it would apply an abuse of discretion standard of review and that it adopted a stricter standard only after the trial was over. Mr. Conley contends that this shift undermined his ability to present his case effectively. He does not, however, indicate what he would have done differently had he known that the trial court would use the stricter scrutiny that he felt was appropriate. Since Mr. Conley had to present a stronger case under the deferential standard that he believed that the trial court was applying, moreover, we fail to see how he was harmed if the trial court instead applied a stricter, less deferential standard of review.

IV.

Mr. Conley further maintains that the trial court should not have allowed the defendants to introduce new evidence and should not have considered the defendants *post hoc* explanations for their decision to deny him additional long-term disability benefits. It is true that in reviewing a denial of benefits under an employee welfare plan subject to ERISA, a court must focus on the evidence available to the plan administrators at the time of their decision and may not admit new evidence or consider *post hoc* rationales. *See Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 620 (8th Cir. 1998),* and *Short v. Central States, Southeast and Southwest Areas Pension Fund, 729 F.2d 567, 571 (8th Cir. 1984).* This is so even in the case of *de novo* review unless there is good cause to depart from the general rule, as the trial court itself pointed out. *See, e.g., Donatelli v. Home Insurance Co., 992 F.2d 763, 765 (8th Cir. 1993).* But the trial court in Mr. Conley's case did not consider any evidence or reasoning outside the record until it noted that *de novo* review on an expanded record would produce the same conclusion. In other words, Mr. Conley was no better off when the trial court considered only the existing record (as he had requested).

Mr. Conley also makes the more serious allegation that the trial court restricted him to the administrative record but allowed the defendants to introduce new evidence that was favorable to them. Specifically, Mr. Conley alleges that the trial court refused to consider the deposition of his personal physician, Dr. W. H. Elliott. As evidence that the court ignored Dr. Elliott's testimony, Mr. Conley points to the fact that there is no reference to that testimony in the single paragraph of the trial court's opinion stating that *de novo*

review of the expanded record also supported its finding that the defendants justifiably denied additional long-term disability benefits to Mr. Conley. The lack of a reference to Dr. Elliott in that brief paragraph, however, does not necessarily mean that the trial court failed to consider the deposition. Dr. Elliott's deposition was admitted into evidence, and we see no reason to believe that the trial court failed to take it into account.

The absence of Dr. Elliott's name from the trial court's discussion of *de novo* review is also the basis for Mr. Conley's argument that the court failed to apply the principle that a treating physician's opinion is entitled to greater deference than the opinion of a reviewing physician. *See, e.g., Donaho, 74 F.3d at 901.* Again, we cannot say that the trial court failed to give proper weight to Dr. Elliott's opinion. The court refers to Dr. Elliott's letters and reports (although not to his deposition) throughout its opinion, and there is no doubt that it weighed this evidence against that of the other four physicians who saw Mr. Conley (including an orthopedic surgeon, Dr. John Kenney, whom Mr. Conley consulted independently). The rule is not that a treating physician's opinion trumps all other evidence but that a court must give it appropriate weight. We see no indication that the trial court in this case failed to do so.

V.

Mr. Conley next asserts that the trial court should have required the defendants to use the so-called *Polaski* factors to evaluate the validity of his subjective complaints of pain. *See Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984) (per curiam* order). It is only when subjective complaints are the basis for a disability claim under social security or the provisions of the Railroad Retirement Act, however, that

Polaski is of relevance. *See, e.g., Fountain v. Railroad Retirement Board, 88 F.3d 528, 531, 531 n.3 (8th Cir. 1996).* Mr. Conley's suggestion that *Donaho* extends the principles laid down in *Polaski* to ERISA cases is not persuasive; *Donaho, 74 F.3d at 901,* applies only the proposition, borrowed from social security cases, that a treating physician's opinion is entitled to special deference. We see no reason to import wholesale, into what is essentially a private-law area, special rules developed for reviewing the decisions of administrative agencies.

Mr. Conley similarly suggests that once he established that he was unable to perform his own job, the defendants had the burden of showing that jobs were available in the national economy that he was capable of performing. Since he suffered from a nonexertional impairment, namely, pain, Mr. Conley argues that the defendants could meet this burden only by using vocational expert testimony or other similar evidence. *See Neely v. Shalala, 997 F.2d 437, 441 (8th Cir. 1993),* and *Sanders v. Sullivan, 983 F.2d 822, 823 (8th Cir. 1992).* This procedure, however, is the special creature of social security, *see* 20 C.F.R. Pt. 404, Subpt. P, App. 2 § 200.00(e)(2), and has no relevance to Mr. Conley's case.

Mr. Conley submits in addition that the trial court erred when it stated that the award of social security benefits to him was not entitled to any particular weight in the overall consideration of his claim, Mr. Conley cites *Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 572 (8th Cir. 1992),* for the proposition that when a plan provides that a claimant must be eligible for social security benefits in order to qualify for plan benefits, then the plan must award benefits to any claimant who is receiving social security benefits unless the plan's definition of "disability" is more restrictive than that required for social security benefits, *see 42 U.S.C.*

416(i)(1)(A). We believe that this reading of *Cox* is too broad. It is in any case irrelevant to Mr. Conley's situation because the defendants' plan makes no reference to a claimant's eligibility for social security benefits.

Mr. Conley also draws our attention to *Ladd v. ITT Corp., 148 F.3d 753, 755-56 (7th Cir. 1998),* which holds that when an administrative law judge's assessment is in accord with the unanimous findings of the doctors who examined a plaintiff, then the defendant must give some reason for disagreeing with that assessment. The *Ladd* court further held that when an employer supports a plaintiff's effort to demonstrate total disability to the Social Security Administration, to the extent of providing the plaintiff with legal representation, the employer is estopped from later denying that the plaintiff was totally disabled under an employee welfare plan, especially when the plaintiff's condition has deteriorated in the meantime. *Id.* Even if we were disposed to follow *Ladd,* neither of its conditions is met here: The doctors who examined Mr. Conley were not unanimous, and the defendants did not help him make his case to the Social Security Administration.

VI.

We turn, finally, to the question of whether Mr. Conley was discharged either for exercising any right under the employee welfare plan or for the purpose of interfering with his right to obtain benefits to which he was entitled, both of which are unlawful. *See 29 U.S.C. § 1140.* The trial court found that Mr. Conley was terminated because, more than a year after he had justifiably been denied additional long-term disability benefits, he still had not returned to work or made other acceptable arrangements. This was a lawful reason for discharge, the trial court correctly held, adding that Mr.

Conley never persuaded the court that his termination was in fact motivated by other considerations.

On appeal, Mr. Conley points to the fact that the company records gave "health" as the reason for his termination. This indicates, he says, that his poor health and eligibility for additional long-term disability payments were the real motives for his termination. It is not clear to us from the record whether Mr. Conley made this argument to the trial court. Even if he did, however, we find that, in the circumstances of this case, it was not improper for the trial court to give greater weight to the evidence of a lawful reason for Mr. Conley's discharge.

VII.

For the reasons stated, we affirm the judgment of the trial court.

Footnotes

[1]The Honorable Donald J. Stohr, United States District Judge for the Eastern District of Missouri.

No. 1:92CV25-DJS

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI, SOUTHEASTERN DIVISION

DONALD E. CONLEY,
Plaintiff,

vs.

PITNEY BOWES, INC., PITNEY BOWES LONG TERM DISABILITY PLAN, GEORGE B. HARVEY, CARMINE F. ADIMANDO, and ALLAN A. CRYSTAL, as Trustees of Pitney Bowes Long Term Disability Plan,
Defendants,

and

PITNEY BOWES GROUP LIFE INSURANCE PLAN, PITNEY BOWES RETIREMENT PLAN, PITNEY BOWES MAJOR MEDICAL EXPENSE PLAN and PITNEY BOWES DENTAL EXPENSE PLAN,
Defendant Parties-in-Interest.

July 30, 1997, Decided

July 30, 1997, Filed

COUNSEL:
For DONALD E. CONLEY, plaintiff: S. Sheldon Weinhaus, Partner, WEINHAUS AND DOBSON, St. Louis, MO.

For PITNEY BOWES, PITNEY BOWES LONG TERM DISABILITY PLAN, GEORGE B. HARVEY, as Trustee of Pitney Bowes Long Term Disability Plan, CARMINE F. ADIMANDO, as Trustee of Pitney Bowes Long Term Disability Plan, PITNEY BOWES GROUP LIFE INSURANCE PLAN, PITNEY BOWES RETIREMENT PLAN, PITNEY BOWES MAJOR MEDICAL EXPENSE PLAN, PITNEY BOWES DENTAL EXPENSE PLAN, MICHAEL CRITELLI, defendants: Clark H. Cole, Attorney, Keith A. Rabenberg, ARMSTRONG AND TEASDALE, St. Louis, MO.

JUDGES:
Donald J. Stohr, UNITED STATES DISTRICT JUDGE.

OPINIONBY:
Donald J. Stohr

OPINION:

MEMORANDUM OPINION

Plaintiff brings the instant action under the Employee Retirement Income Security Act of 1974 ("ERISA"), *29 U.S.C. § 1001 et seq.* As indicated in its order of January 24, 1997, the Court construes the second amended complaint as asserting, in Count I, a claim for benefits under the defendant Long Term Disability Plan ("the Plan") pursuant to *29 U.S.C. § 1132*(a)(1)(B), and in Count III, a claim of interference with protected rights pursuant to § 1140. The breach of fiduciary duty claim asserted in Count II has been dismissed for failure to state a claim upon which relief might be granted. See Order and Partial Dismissal dated January 24, 1997.

The remaining claims were tried to the Court sitting without a jury on February 4, 5 and 6, 1997. Having considered the pleadings, the testimony of the witnesses, the documents in evidence, and the stipulations of the parties, and being fully advised in the premises, the Court here sets forth its findings of relevant fact and conclusions of law, in accordance with Fed.R.- Civ.P. 52(a).

Findings of Fact

1. In September 1989, plaintiff lived in Poplar Bluff, Missouri, and worked for defendant Pitney Bowes, Inc. ("Pitney Bowes") as a customer service representative who sold and serviced business machines over a five-county area.
2. Plaintiff was then covered by the defendant Long Term Disability Plan, an ERISA-governed employee benefit plan sponsored and administered by Pitney Bowes.
3. At all times relevant to this action, the medical staff of the Disability Department which handled plaintiff's claim for disability benefits under the Plan consisted of a Dr. Julian Levine, Medical Director, and Jane Millar, a registered nurse.
4. Helene Gardner served as "Long Term Disability Administrator" or "LTD Administrator." The summary of Pitney Bowes' various employee benefit plans lists Pitney Bowes, Inc. as the plan administrator as that term is used in the Plan itself.
5. Dr. Levine and Ms. Millar reviewed medical information submitted pertinent to disability claims, and made initial determinations of eligibility for benefits, subject to appeal to the Employee Benefits Committee.
6. On September 26, 1989, while driving to a service call, plaintiff's automobile was rear-ended by another car.
7. Afterward plaintiff drove himself to a clinic or hospital in Poplar Bluff, where x-rays were taken and pain medication was given.

8. Plaintiff saw his personal physician, Dr. Elliott, several days after the accident on September 29, 1989. On that date, Dr. Elliott completed a Pitney Bowes form entitled "Attending Physician's Statement of Disability" indicating a diagnosis of back and cervical degenerative joint disease with acute strain, and that plaintiff was temporarily disabled for all types of work. Dr. Elliott ordered x-rays to be taken and referred plaintiff to physical therapy.

9. At a later visit, Dr. Elliott referred plaintiff to a neurosurgeon from Memphis, Tennessee, a Dr. Donahue.

10. Dr. Donahue deemed the results of an MRI (magnetic resonance imaging) not to explain or support the subjective symptoms reported by plaintiff, and ordered a myelogram, a more invasive test involving the injection of dye into the areas surrounding the spinal column. Plaintiff cancelled the myelogram, because he was unwilling to undertake the drive to and from Memphis and because in his past experience a myelogram had caused a severe headache.

11. Plaintiff's prior medical history included a spinal fusion in the mid-1970's and a laminectomy, from which plaintiff claims to have made a complete recovery.

12. Jan Thompson, a registered nurse employed by ConServCo, met with plaintiff and his wife on November 22, 1989, after plaintiff's workers' compensation file was referred to ConServCo, a disability and medical cost management service, by Travelers Insurance Company, Pitney Bowes' workers' compensation carrier.

13. Jane Millar of the Disability Department maintained regular contact with Jan Thompson at ConServCo, and thereby obtained medical reports and other information provided to Thompson. This information was relied upon by the Plan in making its determination that plaintiff was not totally disabled.

14. Unless otherwise noted herein, the medical information and reports described or referred to in these findings were

part of the Disability Department file and were considered in the making of the Plan's determination of plaintiff's claim.
15. Thompson's report of the November 22, 1989 meeting notes that plaintiff's personal physician, Dr. Elliott, had referred plaintiff to Dr. Donahue, and that Dr. Donahue had performed an MRI and recommended an outpatient myelogram, which plaintiff declined on the ground that he could not tolerate the 4 1/2 hour return car trip from Memphis afterward.
16. Thompson's November 22, 1989 report also describes Dr. Elliott's treatment of plaintiff, including physical therapy, Anaprox, Vitamin B-6 and Vicodin as necessary for pain.
17. At that time, Thompson scheduled an appointment for plaintiff with a Dr. Adams on December 19, 1989, for a second opinion concerning plaintiff's injury and condition.
18. Upon Dr. Adams' recommendation, plaintiff did undergo a myelogram and CT scan, the results of which suggested to Dr. Adams as of January 5, 1990 that plaintiff might have a herniated disc or problems relating to scar tissue from his previous back surgery, and that surgery -- decompression and discectomy -- might ultimately be warranted if further physical therapy did not result in improvement.
19. At a later visit on January 29, 1990, Dr. Adams recommended and discussed surgery with plaintiff.
20. Relative to his workers' compensation claim, ConServCo referred plaintiff to a neurologist, Daniel Phillips, M.D., for evaluation. Dr. Phillips' initial written report to ConServCo, dated February 26, 1990, indicated a largely normal examination and no objective medical findings consistent with plaintiff's reports of pain.
21. On March 8, 1990, after reviewing a myelogram and CT scan of plaintiff, Dr. Phillips noted a significant disc bulge, though not a herniated disc, and generally concurred with Dr. Adams' recommendation that surgery be considered, although he observed that the disc problem would not account for all

of plaintiff's complaints, such as urinary urgency, difficulty maintaining an erection, and interscapular symptoms.
22. Dr. Phillips sent Jan Thompson a letter dated March 19, 1990 summarizing his findings after completion of an EMG (electromyogram) and nerve conduction study on plaintiff on March 16. Dr. Phillips reported chronic changes related to plaintiff's old surgery and no significant findings relevant to plaintiff's complaints of pain.
23. By telephone on March 20, 1990, Jan Thompson related to Jane Millar that Dr. Phillips believed surgery was a reasonable option, that plaintiff was considering obtaining a second opinion, and that if plaintiff ultimately elected not to have surgery then his disability for workers' compensation purposes would be rated on a percentage basis.
24. By letter to Jan Thompson of ConServCo dated April 18, 1990, Dr. Phillips stated his rating of plaintiff as having a cumulative 8% partial permanent disability of the whole person.
25. By that time, plaintiff had indicated his election not to have the surgery which Drs. Adams and Phillips had indicated as an option, based on his concerns about its likelihood of success and the possibility of not being able to walk or control his bodily functions, including sexual function and elimination.
26. Plaintiff's personal physician, Dr. Elliott, wrote a letter/report dated April 23, 1990 summarizing his view of plaintiff's condition, including his opinion that plaintiff was unable to resume his prior duties at that time and plaintiff's limited ability to perform any work. Dr. Elliott drafted the letter at plaintiff's request. The record does not support a finding that the letter was ever submitted to the Disability Department or was in the file upon which the Plan's disability determination was made.
27. In July 1990, plaintiff had himself examined by Dr. John Kenney, an Assistant Professor of Orthopedic Surgery at the

St. Louis University School of Medicine. Dr. Kenney's findings are set out in a letter dated August 3, 1990 to plaintiff's then-counsel, indicating that Dr. Kenney, after reviewing the x-rays, myelogram and CT scan previously performed, was unable to detect a herniated disc and saw no need for any surgical intervention or other additional treatment. Dr. Kenney's findings, which in any event did not support a finding of total disability, were never submitted to the Disability Department and were not part of its file at the time of the Plan's disability determination.

28. On September 24, 1990, Dr. Elliott completed a form entitled "Medical Assessment of Ability to Do Work-Related Activities (Physical)," which was provided to him through the mail or by plaintiff. On the form, Dr. Elliott records his view as to plaintiff's ability to perform various activities, such as sitting, lifting, carrying and others. The record does not support a finding that the form was ever submitted to the Disability Department or was in the file upon which the Plan's disability determination was made.

29. A November 9, 1990 letter by a Travelers claims representative states that at plaintiff's request, Travelers agreed to have an MRI of the thoracic spine performed, to be reviewed by Dr. Phillips. The letter further states that Dr. Phillips found the MRI to indicate only minimal degenerative changes, on the basis of which Dr. Phillips informed plaintiff that nothing more could be done medically to treat his subjective complaints of pain.

30. By letter dated February 16, 1990, from Helene Gardner, plaintiff was informed that his short-term disability benefits would cease "at the end of the 22nd week, February 28, 1990," but that his worker's compensation payments would continue so long as Travelers Insurance Company, Pitney Bowes' workers' compensation carrier, continued to approve plaintiff's classification as disabled.

31. Plaintiff was on long term disability status for one year from March 1, 1990 through February 28, 1991, but received no benefits directly attributable to that status for the reason that his workers' compensation and/or Social Security disability benefits were sufficient to off-set the long term disability benefit to which he would have been entitled.
32. Plaintiff's claim of disability is predicated on his complaints of neck, back and leg pain resulting from the September 1989 auto accident.
33. Plaintiff has never been hospitalized following the September 1989 auto accident, has had no surgeries, and has not undergone any treatment by a pain clinic.
34. Plaintiff has not worked since the date of the accident.
35. On October 26, 1990, a decision favorable to plaintiff was issued on his appeal of the denial of Social Security disability benefits; the decision found plaintiff entitled to a period of disability commencing September 26, 1989 and to disability insurance benefits under the Social Security Act.
36. Plaintiff reported to the Disability Department that he had been awarded Social Security disability benefits, and the department was aware of the appeals ruling in plaintiff's favor at least as early as March 15, 1991.
37. By letter dated April 10, 1991, signed by Helene Gardner as LTD Administrator, Pitney Bowes advised plaintiff that his request for long term disability benefits was denied based on the determination that he was not "totally disabled" as defined in Article 2.20 of the Plan. The letter makes specific reference to Dr. Phillips' 8% partial permanent disability rating as one factor upon which the Plan relied in making its determination.
38. Dr. Levine was the decisionmaker responsible for the denial of plaintiff's long term disability claim on April 10, 1991.
39. Millar credibly testified that plaintiff's subjective complaints of pain appeared unsupported by the objective

medical findings documented in his file, and that plaintiff's skills appeared to be transferrable to other jobs which would not have had the same physical demands as his prior work as a traveling service representative. The Court finds that these conclusions constituted the basis for the denial of plaintiff's claim for long term disability benefits by the Plan.

40. The Disability Department's file on plaintiff erroneously contained a number of records relating to a different individual, a Donald G. Conley, and largely concerning his blood pressure. How and when these materials were placed in the file is not established. Millar credibly testified that these records would not have been taken into account in the consideration of plaintiff's disability claim, because their contents were unrelated to the nature of plaintiff's claimed disability and because examination of the records would have indicated that they were not pertinent to plaintiff.

41. On November 27, 1989, C. Leonard Jones, then Pitney Bowes' Director of Personnel for the Southwestern Division, inquired by telephone of Jane Millar concerning the expected duration of plaintiff's absence from the job.

42. Jones' telephone call was followed by a November 30, 1989 memorandum to Millar requesting that she provide him with any additional information bearing on plaintiff's return to work date before December 8, 1989, when a decision was expected to be made concerning reassignment of plaintiff's territory.

43. Plaintiff had been the sole customer service representative assigned to his territory, and his continued absence raised an issue of coverage for Pitney Bowes' customers in his territory.

44. Over the ensuing months, Jones had continuing contacts with the Disability Department concerning plaintiff's employment status.

45. Jones eventually became aware that plaintiff's territory had been reassigned. In conversations with plaintiff, Jones

inquired about plaintiff's ability to relocate if necessary for another position with Pitney Bowes, if plaintiff eventually became able to return to work. Plaintiff informed Jones that he was not able to relocate.

46. The April 10, 1991 letter plaintiff received stating that his long term disability benefits claim was denied suggested that plaintiff contact Jones concerning his employment status. Plaintiff did not do so.

47. Plaintiff having been denied long term disability benefits, but not having reported back to work, his employment status was unclear. Leonard Jones sent plaintiff a letter dated July 3, 1991 requesting that plaintiff contact him to indicate his determination whether to take a personal leave of absence or terminate his employment.

48. Plaintiff turned the letter over to an attorney, John Bloodworth, who sent Jones a response rejecting both of the options presented in Jones' letter and representing that plaintiff planned to return to work as soon as physically able. The letter also indicated plaintiff's intention to file suit concerning the denial of long term disability benefits.

49. Bloodworth's letter was dated July 12, 1991. At that time, plaintiff did not genuinely anticipate any substantial improvement in his condition, and later that month, plaintiff and his wife moved some 275 miles from Poplar Bluff, Missouri to the Murfreesboro, Tennessee area.

50. Jones referred Bloodworth's letter to Pitney Bowes' legal department, and awaited advice from that department concerning plaintiff's status.

51. Almost one year later, on June 1, 1992, Jones sent plaintiff a letter announcing plaintiff's immediate termination and describing plaintiff's severance benefits.

52. The determination to terminate plaintiff's employment was made by Jones after consultation with Pitney Bowes' legal department. Pitney Bowes terminated plaintiff because he was not on long term disability status, had not requested a

leave of absence, and had not reported for work since the September 1989 accident.

Conclusions of Law

I. Count I -- Claim for Benefits

Article Two, § 2.20 of the Plan defines total disability as follows:

Totally Disabled or Total Disability shall mean that the Participant is unable to perform his own occupation for a maximum period of twelve (12) months after the Qualifying Period and that thereafter he is unable, because of injury or illness, to engage in any gainful occupation or profession for which he is, or could become, reasonably suited by education, experience, or training, unless he is actively participating in an approved Rehabilitative Employment Program, as determined by the Employee Benefits Committee.

Plaintiff was denied benefits after the initial twelve month period, at which time his claim was subject to the more stringent "any gainful occupation" standard. By memorandum and order of July 5, 1996, the Honorable Stephen N. Limbaugh, the United States District Judge then presiding over this action, determined that Count I is subject to review under an abuse of discretion standard because § 7.6 of the Plan grants explicit discretionary authority to the Employee Benefits Committee to interpret and construe the Plan and determine all questions of eligibility and status of plan participants. See *Firestone Tire and Rubber v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989); Donaho v. FMC Corporation, 74 F.3d 894, 898 (8th Cir. 1996).*

The Eighth Circuit's most frequent formulation of the abuse of discretion standard has been that the decision be "supported by substantial evidence" and "reasonable." *Donaho, 74 F.3d at 899.* "Substantial evidence" means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Id. at n.10. The decision need not be the only sensible one, so long as it is supported by a reasoned explanation, based on the evidence, even if there exists a different outcome which is also reasonable. Id. at 899. The unreasonableness of a plan decision can be determined both by the quantity and the quality of the evidence upon which it is based, however, so that if either is insufficient, the decision may be deemed insupportable. Id. at 900.

Furthermore, a less deferential standard of review may apply "if the beneficiary shows that a serious procedural irregularity existed which caused a serious breach of the administrator's duty to the plan beneficiary." *Wald v. Southwestern Bell Corp. Customcare Medical Plan, 83 F.3d 1002, 1007 (8th Cir. 1996), citing Buttram v. Central States, 76 F.3d 896, 900 (8th Cir. 1996).* "The deferential standard will apply, however, unless the beneficiary comes forward with evidence establishing that the administrator acted under a conflict of interest, dishonestly, with an improper motive, or without using judgment." *Wald, 83 F.3d at 1007.* Examples include "where the plan trustee does not inquire into the relevant circumstances at issue; where the trustee never offers a written decision, so that the applicant and the court cannot properly review the basis for the decision; or where procedural irregularities are so egregious that the court has a total lack of faith in the integrity of the decision making process." *Buttram, 76 F.3d at 900.* In such circumstances, "a court may infer that the trustee did not exercise judgment when rendering the decision." *Id.* Buttram emphasizes, however, that "it is not the existence of procedural

irregularities per se that will cause a court to employ a heightened standard of review;" in addition, "those irregularities must have some connection to the substantive decision reached." *Id. at 901.*

Plaintiff urges the existence of procedural irregularities amounting to breach of fiduciary duty warranting the application of this less deferential standard of review.[1] The Court notes, however, that the consideration of evidence beyond that presented to the Plan decisionmaker is not automatic even under de novo review. To the contrary, in *Donatelli v. Home Ins. Co., 992 F.2d 763, 765 (8th Cir. 1993),* the Eighth Circuit, citing with approval the carefully considered conclusion of the Fourth Circuit en banc in *Quesinberry v. Life Ins. Co. of North America, 987 F.2d 1017, 1021-27 (4th Cir. 1993),* has held that even in a case of de novo review, the district court should not permit and consider an expanded factual record in the absence of good cause to do so. In *Quesinberry, 987 F.2d at 1025,* the Fourth Circuit stated that "in most cases, where additional evidence is not necessary for adequate review of the benefits decision, the district court should only look at the evidence that was before the plan administrator or trustee at the time of the determination."

The Court finds largely unpersuasive plaintiff's assertions of serious procedural irregularity or breach of fiduciary duty in the administration of the Plan. Specifically, the Court rejects plaintiff's contentions concerning reliance upon the 8% disability rating, the alleged partiality of Dr. Phillips, inadequacy or non-existence of an administrative record for decision, inclusion in plaintiff's file of records pertaining to Donald G. Conley, and reliance on information developed in connection with plaintiff's workers' compensation claim[2] as constituting procedural irregularities and breaches of

fiduciary duty meriting application of a heightened standard of review.

The Court also rejects as without merit plaintiff's contention that the Plan and its administrators were required specifically to invite or instruct plaintiff to submit information and evidence in support of his claim for benefits. Section 5.2 of Article Five of the Plan provides in pertinent part as follows:

> Proof of Disability -- A Participant shall be required to submit whatever proof the Company may require (either directly to itself or to an independent disability case review organization retained for this purpose), including the statements of one or more duly-qualified physicians, initially and from time to time, as evidence of his Total Disability and of the continuation of such Total Disability[.]

The Court does not interpret this provision as imposing a duty upon the administrator to articulate to the claimant specific requirements of proof. To the contrary, the provision may more reasonably be interpreted as imposing upon plaintiff a duty to submit to the Plan the statements of one or more physicians, both initially and from time to time, as well as any other information he deems appropriate or which the Plan may specifically require of him.

The most persuasive of plaintiff's allegations of irregularity concern the delegation of disability determinations under the Plan and the inadequacy of the denial notice. Nurse Jane Millar testified that the responsibility for claims handling was

delegated by the Employee Benefits Committee to the Disability Department, and that she and Dr. Levine were responsible for reviewing medical information submitted relevant to a claim and for making recommendations or determinations as to eligibility for benefits. The deposition testimony of Michael Critelli, a former member of the Employee Benefits Committee, is also consistent with such delegation of authority as to the initial determination of disability benefits under the Plan.

Article Seven, § 7.1 invests in an Employee Benefits Committee the "general administration of the Plan and the responsibility for carrying out the provisions thereof." Section 7.4 grants the Employee Benefits Committee "final, conclusive, and binding" authority to make determinations and take action "with respect to any question arising out of or in connection with the administration of the Plan." The specific powers and duties of the Employee Benefits Committee are set forth in § 7.6, including in § 7.6(c) the power to interpret and construe the Plan, to determine questions of eligibility and of the status and rights of Participants." Section 7.6(e) authorizes the Employee Benefits Committee to delegate to an Administrative Committee "such powers and duties (other than those set forth in (a), (b), (c) and (d) above) to enable it to administer the Plan." This language appears, then, to make the responsibility to make benefits determinations set forth § 7.6(c) non-delegable.[3] The apparent delegation of benefits determination authority to the Medical Director appears, then, to violate the terms of the Plan.

On the record evidence, the Court has found that Dr. Levine is the decisionmaker who determined that plaintiff was not disabled within the meaning of the "any gainful occupation" standard of § 2.20 of the Plan. The record does not contain any written recommendation or determination by Dr. Levine

or the Employee Benefits Committee as to plaintiff's disability claim, other than the denial letter dated April 10, 1990 written by Helene Gardner, presumably at Dr. Levine's direction. Neither does the record include a written explanation of the rationale for Dr. Levine's decision that plaintiff was not totally disabled within the meaning of the Plan. "The Eighth Circuit has read the statute and the regulations to require the administrator to 'set out in opinion form the rationale supporting their decision.'" *Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 693 (7th Cir. 1992), quoting Richardson v. Central States, 645 F.2d 660, 665 (8th Cir. 1981).* These procedural irregularities may be of sufficient seriousness to undermine faith in the integrity of the decision making process within the meaning of Ward and Buttram, although the Court is not, even in view of these facts, "left with a firm conviction that the denial of benefits was the result of an arbitrary decision or whim." *Buttram, 76 F.3d at 901.*

Upon careful consideration, however, the Court has concluded that in the circumstances of this case, a final determination of such matters as govern the standard of review is not necessary for the reason that under any of the potentially applicable standards outlined above, the Court would uphold the determination that plaintiff is not entitled to benefits under the Plan. The information upon which the Court has found that Dr. Levine based his determination provides substantial and reasonable support for his decision, in that the reports of the several physicians who examined plaintiff suggested the lack of an objective medical basis for plaintiff's subjective complaints of pain, particularly where the pain was alleged to correspond with the September 1989 car accident and the scant objective medical evidence indicated only chronic degenerative conditions associated with plaintiff's preexisting back problems and surgery.

Adjudged on an abuse of discretion standard, then, the disability determination would be affirmed.

Were the Court to apply a de novo standard of review, but limit its consideration to the same evidence as was present in plaintiff's Disability Department file at the time of Dr. Levine's decision, the Court's own judgment would be the same, namely that plaintiff's claimed disability lacked credible supporting medical findings. Because the Court's own determination would be that plaintiff's claimed injury lacked credibility, the Court would also conclude that it did not render plaintiff incapable of any gainful employment, as required for total disability under the pertinent Plan provisions.[4]

This same conclusion would only be further bolstered were the Court to consider the evidence offered by both parties beyond that which was part of the administrative record. For example, the Court finds persuasive in this regard the fact that the findings of Dr. Kenney, the orthopedic surgeon independently consulted by plaintiff, yielded no need for any surgery or other additional treatment.[5] Also highly persuasive in the Court's view is the deposition testimony of Dr. Phillips indicating his suspicions that plaintiff's complaints were exaggerated or unreliable.

For all the foregoing reasons, then, and based on the Court's findings of relevant fact, the Court concludes that the denial of plaintiff's claim for long term disability benefits should be upheld and affirmed. Judgment in favor of defendants will be entered on Count I of the second amended complaint.

II. Count III – Interference with Protected Rights

Section 510 of ERISA, *29 U.S.C. § 1140,* prohibits the discharge of an employee/plan participant "for exercising any right to which he is entitled under the provisions of an employee benefit plan...or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan." The remaining Count III of the second amended complaint alleges that Pitney Bowes' termination of plaintiff's employment violated § 1140. The Eighth Circuit has held that such claims be analyzed under the familiar framework applicable to claims of employment discrimination under Title VII and the ADEA:

If the claimant is able to establish a prima facie case of a violation of § 510, the burden shifts to the employer to articulate a legitimate, nondiscriminatory reason for its action. If the employer does so, the burden shifts back to the claimant to prove that the proffered reason is pretextual.

Kinkead v. Southwestern Bell Telephone Company, 49 F.3d 454, 456 (8th Cir. 1995).

On the facts found by the Court, plaintiff's claim of interference with protected rights fails both because plaintiff has not made out a prima facie case and because plaintiff does not succeed in carrying his ultimate burden of persuading the Court that his termination was motivated by considerations prohibited by § 1140 rather than by the legitimate, lawful reasons found by the Court.

> To establish a prima facie case of deliberate interference with prospective benefits under § 510, a claimant must demonstrate a causal connection between the likelihood of future benefits and an adverse employment action...[Section] 510 of ERISA does not

> prohibit firing an employee who becomes less productive because of an illness or disability.

Id. at 457.

Plaintiff has presented no persuasive evidence that Pitney Bowes terminated him in order to deprive him of benefits under any of the ERISA plans applicable to him during his employment. Instead, the Court has found that Pitney Bowes terminated plaintiff, more than one year after justifiably denying plaintiff's claim for long term disability benefits, because plaintiff failed to return to work or to arrange any other acceptable alternative employment status, such as a leave of absence. His claim for disability status having been rejected, plaintiff was not entitled to remain indefinitely on the payroll despite his failure to return to work, so as to be eligible for other ERISA plan coverages available to Pitney Bowes' employees. On these facts, the Court finds no violation of § 1140, and will enter judgment in favor of defendants on Count III of the second amended complaint.

Conclusion

Accordingly, for all the reasons set forth above, the Court finds in favor of defendants and against plaintiff on the two remaining claims of plaintiff's second amended complaint, seeking review of the denial of long term disability benefits and alleging a termination constituting unlawful interference with ERISA-protected rights. A separate judgment reflecting this disposition will be entered herein this day. Defendants' potential entitlement to attorney's fees and costs will not be considered at this time, but is subject to consideration in the event of the filing of an appropriate motion for attorney's fees in accordance with E.D.Mo. L.R. 8.02 and an appropriate bill of costs in accordance with E.D.Mo. L.R. 8.03.

Donald J. Stohr

UNITED STATES DISTRICT JUDGE

Dated: 7/30/97 JUDGMENT
Pursuant to the memorandum opinion filed herein this day, **IT IS HEREBY ORDERED, ADJUDGED and DECREED** that judgment is entered in favor of all defendants and against plaintiff on the remaining Counts I and III of plaintiff's second amended complaint.
Donald J. Stohr
UNITED STATES DISTRICT JUDGE

Dated: 7/30/97

Footnotes

[1] Unlike the Court, defendants have construed plaintiff's arguments on this point to be an unavailing attempt to resurrect plaintiff's earlier dismissed Count II asserting a distinct cause of action for breach of fiduciary duty.

[2] See *Brown v. Retirement Committee of Briggs & Stratton, 797 F.2d 521, 531 (7th Cir. 1986).*

[3] At least one employee bulletin, entitled "Getting Back to Business: the Disability Management and Rehabilitation Program," explicitly stated the apparent actual practice of the Plan, namely for benefits eligibility to be determined by the Medical Director, upon review of any medical information submitted by the claimant and any additional medical information obtained by the Plan through referral.

[4] The Court notes that the award of Social Security disability benefits to plaintiff is not binding on the Plan's determination. Plaintiff is unable to cite any provision of the

Plan, and the Court has found none, which prescribes any particular consideration for a Social Security determination in connection with the Plan's determination of disability. The fact of plaintiff's Social Security award was in the plaintiff's file with the Disability Department and was therefore presumably given some consideration by the Medical Director, although it was not entitled to any particular value in the overall consideration of plaintiff's claim. See *Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 572-73 (8th Cir. 1992); Davis v. American General Life & Accident Ins. Co., 906 F. Supp. 1302, 1311 (E.D.Mo. 1995)* [Limbaugh, J.].

[5] That this is so may explain plaintiff's failure to submit Dr. Kenney's findings to the Disability Department for consideration in connection with his claim for benefits.

No. 97-3963EMCG

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

Donald E. Conley,
Appellant,

vs.

Pitney Bowes, etc., et al.,
Appellees.

June 24, 1999, Decided

DECISION WITHOUT PUBLISHED OPINION

OPINION:

Order Denying Petition for Rehearing and for Rehearing En Banc.

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.